UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

*UNITED STATES OF AMERICA	
v.	CRIMINAL ACTION No. 04-10166-RGS-1
DAVID CARL ARNDT	

BEFORE THE HONORABLE RICHARD G. STEARNS
UNITED STATES DISTRICT JUDGE
DISPOSITION
December 19, 2006

APPEARANCES:

UNITED STATES ATTORNEY'S OFFICE, (By AUSA Nancy Rue), 1 Courthouse Way, Suite 9200, Boston, Massachusetts 02210, on behalf of the United States of America

ECKERT SEAMANS CHERIN & MELLOTT, LLC, (By Stephen R. Delinsky, Esq., and Robert Delahunt, Esq.), 99 Summer Street, Suite 1800, Boston, Massachusetts 02110, on behalf of the Defendant

Courtroom No. 21
1 Courthouse Way
Boston, Massachusetts 02210

James P. Gibbons, RPR, RMR
Official Court Reporter
1 Courthouse Way, Suite 7205
Boston, Massachusetts 02210
jmsgibbons@yahoo.com

P R O C E E D I N G S

THE CLERK: Court is open. You may be seated.

This is United States of America versus David Arndt, Criminal No. 04-10166.

Would counsel please identify themselves for the record.

MS. RUE: Good afternoon, your Honor. Nancy Rue for the United States.

MR. DELINSKY: Stephen Delinsky for the defendant, David Arndt, your Honor.

MR. DELAHUNT: Good afternoon, your Honor. Robert Delahunt with Mr. Delinsky.

THE COURT: I'm sorry for the brief delay. I had just been faxed Dr. Fayne's evaluation, which I had not seen, and I wanted to be certain I read it prior to this hearing.

Obviously, I read the presentence report, as I know all counsel and Dr. Arndt have done.

I have read the sentencing memorandum submitted by the defendant as well as the memorandum that was submitted earlier today by the government.

I have read, which is attached to the presentence report, Dr. Amador's evaluation, which is presented at some length.

As we know, the original plea agreement had been

premised on the assumption that the safety valve provision would apply. I think it's been since determined by the Probation Office that it does not. So what was originally a Guideline calculation, as I recall, of 108 to 135 months, recognizing that the Guidelines calculations are advisory at this point in our jurisprudence, rather now the Probation Office recalculates the Guideline range as 151 to 188 months.

Putting aside the basis for that calculation, I know a number of objections of a factual nature were submitted by the defendant, most of them of a historical nature, and it appears to me they have been addressed fairly thoroughly by the probation officer in the addendum to the presentence report.

There is, without the safely valve, of course, the complicating factor that there is a minimum mandatory sentence, as I recall, of ten years that attaches to two of the counts of conviction.

MS. RUE: Yes, your Honor.

THE COURT: Ms. Rue, why don't we begin with the government.

Mr. Delinsky, you were going to call a witness, I believe?

MR. DELINSKY: Yes. I was going to call Dr. Amador.

THE COURT: Just to set a parameter, let me begin with the government's recommendation to the Court, and then we will proceed with the defendant's presentation.

MS. RUE: Your Honor, the government recommends a sentence of 170 months.

This is a case in which the defendant has had numerous opportunities to conform his conduct to the law. There are so many defendants that appear in front of this Court who have never breathed the possibilities of the opportunities that related to this defendant, and yet he became a methamphetamine user and he became a methamphetamine dealer.

This is a devastating drug. It's had a crippling effect on the gay community in Boston. It's had a crippling effect on society, and we believe that a sentence under the Guidelines at the middle of the guideline range is appropriate.

We believe that the items submitted as mitigating by the defendant are not, in fact, mitigating for the reasons submitted in our sentencing memorandum.

This is a defendant who's had multiple opportunities to conform his conduct. He has chosen not to do so, and a Guidelines sentence is appropriate.

THE COURT: Mr. Delinsky.

MR. DELINSKY: Yes, your Honor.

We also submitted electronically some sentencing letters to the Court yesterday.

THE COURT: I did not see those.

MR. DELINSKY: I am going to give the originals to you now. The government has been provided them. There are three letters.

THE COURT: If you do not mind pausing while I read them.

MR. DELINSKY: Sure.

(Pause in proceedings.)

THE COURT: Dr. Silen's letter, Dr. Biolio's letter and Rabbi Goodman's letter, and those will become part of the record.

MR. DELINSKY: Thank you, your Honor.

I am going to approach my argument, Judge, from a very basic premise.

Both the government and I, when we negotiated the plea agreement, believed that Dr. Arndt qualified for the safety valve, and it was so stated in the plea agreement.

And at the plea itself, you asked Assistant United States Attorney Cynthia Lie what her calculation of the proper level would be based upon her knowledge, and she said it would be Level 30, 31, and that was consistent with our understanding of the application of the safety valve in this case.

Subsequently, the Probation Department determined that some of the offense conduct occurred when Dr. Arndt was on probation from a federal misdemeanor conviction in New Orleans, and according to the Guidelines, if such an event happens it causes a triggering event to increase the criminal history score, and that's what the Probation Department determined. And one of the qualifications in order to be qualified for the safety valve is to have a criminal history score no greater than I.

So that necessitated a hearing before this Court where Dr. Arndt said that he felt obligated not to withdraw his plea and that he was prepared for all consequences that could occur, notwithstanding the advice that he had been given that may not have been correct, and then we proceeded.

So I think it's quite dramatic that at one time you have the government being prepared to support a safety valve and an appropriate sentence thereunder, and now with no additional facts, except the application of the Guidelines, to say it's a 170-month sentence.

We have made various arguments, two key arguments, why this Court can grant David Arndt the safety valve.

The first argument is based upon constitutional avoidance, and the series of United States Supreme Court cases that talk about prior criminal history and the effect that those cases have today in light of Booker, in light of

Fan Fan, and in light of some of the dissenting opinions that occurred from some of the majority of the Supreme Court when the Almendarez-Torres case was first decided in 1998.

I have stated in the sentencing brief all of the cases, all of the dissents, as recently as Judge Souter's comment about constitutional avoidance and trying to deal with these issues; both the statement of Justice Thomas and Justice Scalia, talking about, primarily in the Shepard case decided in 2005, Justice Thomas, who was part of the majority in the Almendarez-Torres case, stated, "Innumerable criminal defendants have been unconstitutionally sentenced under the flawed rule of Almendarez-Torres, despite the fundamental imperative that the court maintain absolute fidelity to the protections of the individual afforded by the notion of trial by jury and beyond a reasonable doubt requirements."

As a result of those cases and of the case law that has occurred post Booker, our contention is that the prior conviction that occurred in New Orleans in 1999 that serves as a trigger to take Dr. Arndt out of the safety valve should have been charged either in the indictment or admitted to in the plea colloquy according to these constitutional standards.

Either of those events did not occur.

So, consequently, now we're left with the concept

of judicial fact finding. And I know there is a prior conviction exception that is talked about in Booker. I know our own First Circuit when confronted with this, as the United States Attorney has pointed out, has affirmed the United States Supreme Court precedent while recognizing it is highly doubtful and in great disrepute in saying the First Circuit feels obligated to still follow it.

I'm not debating what the Assistant United States Attorney submitted in her sentencing brief on the First Circuit's position, but I am also aware of other courts that have taken the language of Justice Souter, of Justice Scalia, Justice Thomas -- without Justice Thomas' vote, that five-to-four majority opinion would have been void, and he has tried to, in numerous decisions, to have that case revisited as both an Apprendi issue and now a Booker issue, and from the case law it clearly applies to mandatory minimums.

And so that area of the law is in tremendous flux, and I suggest the next time the Supreme Court hears that, or has an opportunity to decide it, it will rule that in mandatory minimum cases where a triggering will occur to take somebody into the mandatory minimum and not to a safety valve, that that has to be affirmatively pled and admitted.

It was not in this case, and, therefore, I have submitted that this Court has the authority under Booker to

declare that the Guidelines are advisory on this point and to give Dr. Arndt credit for the safety valve.

I then go on to postulate that if that's true, there are other grounds that this Court can utilize in helping itself to come to an appropriate Guideline sentence.

First of all, I contend that when this offense conduct occurred, the 2002 Guidelines book was in effect. The 2003 Guidelines book did not take effect until late October of 2003, and then subsequently the 2004 Guidelines book and now the 2006.

It's the position of the Probation Department that the 2006 Guidelines book now governs because that's when Dr. Arndt is being sentenced.

The rule is, as I understand it and as has been recently affirmed by our First Circuit in Thurston, that the Guidelines in effect at the time of the offense conduct should govern it if it is more lenient, and the Guidelines in effect in 2002 were more lenient.

First of all, in 2002 there was no First Circuit decision. There was no guideline which stated that a criminal history that overstates the seriousness of the offense cannot be applied to a safety valve situation.

Subsequently, the Guidelines were amended, after the offense conduct occurred in this case, to prohibit a departure based upon criminal history overstates the

seriousness. But at the time of the offense conduct, that guideline as written by the Commission and approved by Congress did not restrict the Guidelines at all to safety valve cases. Some circuits did, but the First Circuit was absolutely silent on that issue.

So we then make a presentation as to why -- as to what Dr. Arndt's criminal history is.

The only conviction that brought him, in our judgment, to Criminal History I was a misdemeanor conviction, where he sought to aid, illegally, inappropriately, his lover, who was faced with deportation back to a country that actively discriminated again homosexuals. He tried to protect him from being deported.

He was originally charged with a felony, as the government points out, but the Court in its wisdom said that it would accept a plea to a misdemeanor, the United States Attorney's Office agreed, and gave Dr. Arndt three years' probation.

The triggering event in this whole series, in this indictment before the Court, is a serious activity of conduct that the defendant is charged with committing from the spring of 2003 up until including the beginning of August of 2003, dealing with the sale of methamphetamine, very serious offenses, that bring his guideline calculation very high and trigger potentially a mandatory minimum.

The government in its wisdom in the same indictment chose also to charge Dr. Arndt, while he was still a physician, with writing scripts for Oxycondone to a drug dealer by the name of Charles Ghera, who Dr. Arndt was buying crystal meth from at the time as a user.

Dr. Arndt has admitted that Charles Ghera was not a patient; that he didn't see Charles Ghera in his office, and met Charles Ghera as somebody who he would buy crystal meth from. Dr. Arndt has pled guilty to those offenses.

What raises his criminal history is that towards the end, over the last few months of his probation -- his probation ended in January of 2002. So there was one event in January and two more, I believe, in January of 2002. These scripts were written. And that triggered, according to the Guidelines, an increase of his criminal history from I to III. The triggering event was a misdemeanor, but while on probation.

So in a way he's being doubled punished, because he was punished originally for his first misdemeanor offense. He is being punished for the Oxycodone offenses, which he pled guilty to, and now the triggering event under the Guidelines which could take him out of the safety valve.

You will hear testimony that but for the long preexisting mental illness that Dr. Arndt has suffered from, at least since the age of 13, 14, or 15 years old, he would

not have committed this offense conduct, and that the bipolar disorder that Dr. Arndt suffers from was very severe; and when he was a young man, a young boy, really, he began self-medicating with drugs, which caused him at a very young age to attempt suicide twice, for which he was hospitalized for weeks, put on medication, and then antipsychotic medication.

From there he had other offenses that dealt with antisocial behavior, dealing when he was 19 years old, to a street offense in California that he engaged in in order to buy money -- in order to have money for drugs.

According to Dr. Amador, this man has not been drug free since he was 14 or 15 years old until basically he's been locked up under these charges since June of 2004; that for basically 25 years he's been using drugs, and he's been using drugs as a direct consequence of this underlying mental illness to deal with a severe depression that bipolar disorder brings on. And these drugs have ranged from marijuana, to LSD, to angel dust, to cocaine, to heroin, to methamphetamine, and, most recently, to smoking crystal meth, which gave the defendant the highest level of relief he had ever experienced.

And what complicates this matter, of course, is that while this was occurring and that while he was a chronic drug abuser, he was able to achieve in some parts of

his life great excellence, great academic achievement, and great promise as a physician.

He is not the only physician that has become drug addicted with serious problems, and Dr. Amador will talk to you about Dr. Fayne's specialty in treating drug-addicted physicians, and how he headed a very famous program in New York City dealing with drug-addicted physicians, and his opinion of the root cause of Dr. Arndt's drug addiction.

So these facts, I believe, coupled with Dr. Arndt's history, I think will lead the Court to conclude that his criminal history does overstate the seriousness of his level, that could cause this Court, one, under this authority under Booker, to grant the safety valve and then apply the criminal history standard, or under the sentencing standards outlined in Booker that the Court should follow as set out in the statute and as reemphasized recently in the Thurston case. That was the second time it was decided this summer, which the First Circuit laid out, for Mr. Thurston it said, you know, we've reversed the district court before, twice before, and each time it is granting Mr. Thurston these downward departures that we don't think are allowed under the Guidelines but under Booker. Even though they don't meet the technical standards of the written Guidelines, they still qualify as variances under Booker and under the statute, and outlined for the district court what

it could use to reduce the five-year sentence to some 30-some-odd months, applying what they said were flawed traditional downward departures.

Most recently the First Circuit this summer decided the Feliz case. Your Honor was the sentencing judge in that case, and that was a safety valve case in which the government contended, and this Court found, that the defendant did not meet the requirements of the safety valve because he did not proffer truthfully all the information; again, one of the prongs of the safety valve. And the First Circuit went on to analyze this Court's ruling and affirmed this Court's finding that the safety valve did not apply; That the Court was correct in its analysis in saying that the safety valve did not apply because it did not meet one of these prongs.

The First Circuit then stated, "What is left is the contention that the Court misunderstood Booker when it imposed sentence. Booker, of course, rendered the Guidelines advisory, giving the district courts a freer hand to fashion appropriate sentences. The Court here, however, did not exercise its new-found freedom, concluding the Guidelines-recommended sentence was appropriate."

I then state in the sentencing brief, The language of the First Circuit is clear and unequivocal, that this Court has the authority to apply Booker for Dr. Arndt even

if it determines that he's not eligible for the safety valve relief under the Guidelines."

I don't think the First Circuit announces nullities. Here it's saying this summer Judge Stearns was correct saying the safety valve did not apply, but he had also freedom under Booker to fashion an appropriate sentence. The Court, however, did not exercise its new-found freedom.

If this court -- if the district courts had no freedom to apply Booker adjustments to safety valve ineligible cases, why would the First Circuit state that language? It is clear. It is unequivocal.

So, one, in summary, our legal argument to allow Dr. Arndt freedom from the mandatory minimum is based upon the doctrine of constitutional avoidance and our analysis of the appropriate Supreme Court cases in light of Booker and Fan Fan and Apprendi. And, two, even if this Court finds or reasons that it will not apply that standard to give -- to say that Dr. Arndt is safety valve eligible, the First Circuit case of the United States v. Feliz gives the Court that authority to apply the statutory standards that's allowed to consider these other -- to give Dr. Arndt sentencing relief.

And the sentencing relief that we're talking about is based upon a combination of factors. One, that his

criminal history overstates the seriousness of the offense; the significant vulnerability in prison that Dr. Arndt has experienced and will experience. He has been held in federal detainee custody since June of 2004, basically in three institutions, Norfolk, Bridgewater Hospital, Plymouth, and then back to Norfolk. The Court has seen that when he was first incarcerated he was suicidal, and they had to put him on a suicide watch and they had to send him to the State Hospital.

The Guideline in effect at the time of the offense conduct allows for the Court to consider it. I set out the cases, the leading cases, the United States Supreme Court case of Koon. I talk about even the notorious Noriega case, where he had to be held in solitary confinement because of who he was and the Court said, Wait a second, we're going to reduce his sentence basically by 25 percent because that's cruel.

The Police Officer, Volpe, who was charged in the notorious case out in New York of taking a Haitian immigrant and doing all kinds of unspeakable things to the immigrant while the immigrant was in police custody, the court, even under those horrific conditions, provided a downward departure because of what Volpe faced in prison.

Dr. Amador will also testify, as the case law indicates, in his professional opinion about the

vulnerability that Dr. Arndt will face in prison.

We also talk about extraordinary acceptance of responsibility. As your Honor knows, the 2003 Guidelines that went into effect at the end of October of 2003 outlawed that departure. However, the Guidelines in effect for the offense conduct allowed that departure, and if your Honor looks at the plea agreement in this case, both the defense and the government stipulate that the appropriate Guidelines book is the 2002 book. It's stated in black-and-white language. Both sides agreed to that.

And under the 2002 Guidelines book, when the offense conduct in this case took place, it allowed for extraordinary acceptance of responsibility.

Now, the government has claimed that Dr. Arndt pled guilty because of the overwhelming nature of the facts against him.

Dr. Arndt pled guilty because he said he was guilty. Dr. Arndt had defenses which he decided not to pursue because of his conviction of what he had done, and when he was given an opportunity by this Court, that many defendants would have availed themselves to do, to start the system anew, to refight, he said no. I know what I've done. I know what I pled guilty to, and if it results in a harsher sentence to me, different than the one I anticipated, that's why I pled guilty, because I am guilty.

If your Honor looks at the cases that I have cited to justify this departure, it will find very similar cases where other courts have said like conduct warrants a departure for that level of acceptance of responsibility.

I think Dr. Arndt's statement to the Court as we outline -- as we restate in the sentencing brief, is very compelling. But there are cases where defendants persisted in pleading guilty despite the fact that a codefendant's motion to suppress was granted. There were other defendants who entered an Alford plea, an Alford plea, where he left open the concept of admitting real guilt but yet testified at another's trial and admitted his full participation in the case in order to exonerate an innocent person. So he exposed himself to greater punishment by his willingness to testify. The Court felt that that defendant by doing that, by compromising the effectiveness of that Alford plea and preserving that level of doubt, showed an extraordinary level of acceptance of responsibility and, therefore, decided to grant a downward departure.

We've cited all these cases.

When Dr. Arndt gave the proffer to the United States, the plea agreement was alive and valid. That was being negotiated. It had not yet been finalized, and we understood as one of the requirements for a safety valve he had to proffer truthfully.

He came in, and according to the government, as they stated in the plea agreement a number of months later, he did proffer truthfully. The one element of the safety valve the government has complete control over is that proffer, and they say it right in the plea agreement that he did proffer truthfully. At the end of that proffer there was some discussion about the government meeting again. I don't necessarily mean the United States Attorney's Office, but the agents were interested in additional intelligence. And while Ms. Lie was still on the case, before the issue of the plea agreement and whether the safety valve still applied or not, there were discussions about bringing Dr. Arndt in again to discuss issues. And those conversations continued after the whole issue of the validity of the safety valve came into question. They weren't initiated then. They were continued then.

And when the current Assistant United States Attorney, Ms. Rue, took over, we tried on numerous occasions to schedule times when Dr. Arndt could be debriefed on the issues that are articulated in the government's sentencing memorandum.

I agree with the characterization, not necessarily the conclusions, about the information he had that we had proffered in a letter to the government. And as little as a number of weeks ago after this case has been continued,

according to the Assistant United States Attorney, she was still trying to set up such a meeting.

So I disagree with the government's characterization that Dr. Arndt's attempt to come in again to provide information about how crystal meth is distributed in the gay community and the unique ways he feels it could be fought, additional background information on numerous individuals associated with the crystal meth drug trafficking trade in Greater Boston, his own ideas about drug trafficking as applied to crystal meth being applied, there is no better spokesman for somebody who understands now, in the light of hindsight, the devilish and evil quality of that drug than Dr. Arndt. So I disagree with that characterization.

So I believe those two characteristics, one, his steadfast orders to me that he wasn't going to game or manipulate the system, that he was not going to disrupt these proceedings by starting again from zero, by accepting the consequences of possibly flawed legal advice, and, number two, of his sincere efforts to cooperate.

And then the last ground is diminished capacity.

The 2002 Guidelines were amended in 2003 to make the granting of a downward departure on account of diminished capacity more difficult because a different prong was added, that besides the requirement that the defendant

suffer from a substantial mental illness, that there was a causal effect between the mental illness and the crime.

And even though I contend the 2002 Guidelines govern, Dr. Amador's report is premised on the Guidelines in effect now, the more stringent test for the downward departure for diminished capacity.

So with that preface, that is why I would like to call Dr. Amador to the stand, your Honor.

THE COURT: You may do so.

MR. DELINSKY: Thank you.

Dr. Amador.

XAVIER AMADOR, sworn

THE CLERK: Please state your name for the record, and would you spell your last name, please.

THE WITNESS: Xavier, X-A-V-I-E-R, Amador, A-M-A-D-O-R.

DIRECT EXAMINATION

BY MR. DELINSKY

Q Dr. Amador, what is your occupation?

A I'm a clinical psychologist.

Q And briefly, what's you educational background?

A I have a BA in Psychology from State University of New York, a Master's Degree in Clinical Psychology from New York University, and a Ph.D. in Clinical Psychology from New York University.

Q And how long have you had your Ph.D.?
A Since 1989.
Q And what professional training have you had?
A Well, a range of experiences that are common in clinical training for a Ph.D., externships, internships in neuropsychology, substance abuse certainly, family therapy. A wide range.
Q And what teaching positions have you had?
A I was in the Department of Psychiatry at Columbia University, College of Physicians and Surgeons, from 1989 until 2002.

During most of that same period, I was an adjunct at Columbia University in the Department of Clinical Psychology, where I still am a professor there, and I've had other adjunct positions at other universities in the area.

Q What specialty, if any, have you had in your field?
A Well, my clinical practice is general, so I see all sorts of patients. I certainly see patients with mood disorders and substance abuse disorders.

But my academic and research career has been focused on two main issues: Reliability of diagnoses. So I've worked on the DSM, the diagnostic manual that we all have used for over a decade; and then more specifically I've worked on the problem of poor insight, people with bipolar disorder, schizophrenia, people who don't believe they're

ill, and the nature of their problem and its effect on judgment.

Q Have you written in the field on schizophrenia and/or bipolar disorders?

A Yes, about a little over a hundred peer-reviewed articles on schizophrenia and bipolar disorder.

I have three books on those, on mood disorders. One of them focuses entirely on the problem of lack of insight. That's called, "I Am Not Sick. I Don't Need Help."

Q Previous to --

A Actually two of them focus on it. Another one is a peer-reviewed one, sorry, "Insight in Psychosis."

Q Previous to your appearance here today before the Court, have you been qualified to render opinions about mental states in the federal district courts of the United States, in the military courts of the United States, and in the state courts of the United States?

A Yes, approximately 15 times.

I'm sorry to interrupt. Could I get some water?

Q Yes.

(Pause in proceedings.)

Q Now, I asked you to examine Dr. Arndt to render an opinion in this case; is that correct?

A Yes.

Q And prior to doing so, did I explain to you the diminished capacity sentencing guideline in effect as of the offense conduct and then subsequently in effect as of now?
A Yes.
Q And did I ask you to render an opinion based on the diminished capacity guideline in effect now, even though it was more strict than the Guidelines in effect at the time of the offense conduct?
A Yes, you did.
Q Have you rendered an opinion in this case?
A I have.
Q And what did you do in order to render an opinion?
A Well, I met with Dr. Arndt a number of times over a period of two years, four times total I believe, three times by the time I wrote my report, and then again yesterday.

I reviewed a large number of documents that I won't go through the list now. It's appended to my report.

I did a very extensive psychosocial history, determined that he has had a mental disorder since the age of approximately 13, most notably bipolar disorder with frequent episodes of depression, major depressive disorder, and multiple or problem substance abuse since that age. He has really been struggling with trying to -- with addiction for about 30 years.
Q And do you have an opinion as to whether Dr. Arndt

suffers from a diminished capacity?
A Yes.
I'm sorry. You did ask me that.
As a result of those disorders, I believe he does. I believe that certainly with respect to the offenses that we're discussing here today --
MS. RUE: Objection, your Honor.
THE COURT: Overruled.
A -- that he evidenced diminished capacity to employ the power of reason and to control his behavior as a result of those disorders that I just listed.
Q Now, do you have an opinion as to whether or not Dr. Arndt suffers from a significantly reduced -- suffered from a significantly reduced mental capacity at the time of the offenses?
A Yes.
As I said, during the time of the offenses that we're here about today, that I understand that we're here today for the Court to hear evidence about, he did suffer from diminished capacity.
Q And do you have an opinion as to whether or not the significantly reduced mental capacity contributed substantially to the commission of these offenses?
A I do.
I feel certain within a reasonable degree of

professional certainty he would not have done any of these offenses had he not had this mood disorder and the concomitant substance abuse disorder.

Q Can you outline for the Court your reasons for these conclusions?

A When doing this kind of assessment, I am looking at the defendant's entire life history. So the best place to start is when I first identified this, and I can do it very briefly, because, as the Judge mentioned, I wrote a detailed report about it.

But Mr. Arndt when he was 13 years old was suffering from Ehlers-Danlos syndrome. It's E-H-L-E-R-S - D-A-N-L-O-S, I believe.

We know, and I'm not sure we knew this back in the mid '70s, that this is associated with a number of psychiatric disorders, including depression. And, in fact, that's what I was able to elicit.

I also, in addition to interviewing Dr. Arndt, read interviews that were done by an investigator of various people in his life. I interviewed his parents as well.

And what clearly emerged was that he had his first episode of major depression at the age of 13.

At the time he, because of the social context he was in, had his first introduction to drugs, smoking marijuana, barbiturates.

He shortly after that, because of the EDS, the syndrome I just mentioned, had major surgery. It's a disorder of the connective tissue in the body. He had major problems with a dislocation of his shoulder. He had surgery and was in a body cast for about three months at the age of 15. Sunk into a very deep depression. He was given opiates to manage the pain postoperative and then in the months after that.

So in addition to barbiturates that he was getting, he also learned, I think, a very unfortunate lesson, that the opiates not only helped him with his physical pain, but they also helped him with his depression.

And the thing about depression and clinical depression is it's not just a depressed mood. We're talking about a constellation of the systems that go on for a couple of weeks or longer.

So what I say to family members when I'm trying to explain depression in a relative is think of your absolute most depressing moment, perhaps the death of a loved one, and that goes on for weeks and months. And, in addition, you hate yourself. You're filled with self-loathing. In addition to that you see absolutely no future whatsoever, no hope of relief. Your judgment is impaired. We know there is cognitive impairment with depression. And it's a highly fatal disease, bipolar depression especially. About

15 percent of sufferers die from the disease. The brain essentially short circuits the will to live. Judgment is so severely impaired, reason is so severely impaired, that people who are ill with this illness, like David Arndt was at the age of 15, cannot look at their future, cannot see hope, cannot see any other choice but to end their lives.

He studied his father's medical books and slit his wrists vertically. He drank vodka and took barbiturates, and he would have died had his sister not found him.

Q What, if anything, does the medical literature indicate as a causal connection between the Ehlers-Danlos syndrome and subsequent mental illness?

A That children and adolescents with this disorder are, as many as 70 percent in one study, suffer from depression and anxiety disorders and related psychiatric disorders.

In addition to that, Dr. Arndt has a number of risk factors for developing mood disorders and substance abuse disorders. He has first-degree relatives also with mood disorders and with substance abuse disorders, which increases his risk from 4 to 6 percent higher than the average person.

So he's got this medical illness that causes 70 percent of suffers to develop psychiatric illnesses. He has a family history, genetic vulnerability.

He learns really a terrible lesson at the age of

15, and this is linked to social stressors. He was outed as a homosexual, lost all his friends.

And, as I said, when you're in the midst of a clinical depression, this is not normal depression, your judgment can be very severely impaired to the point that your vision is tunnel vision. You see one possible solution, to end the pain. And that solution in this instance, it wasn't the only time he tried, was to take his own life.

Q I take it that after the first suicide attempt there was a subsequent suicide attempt by pills, overdose of pills?

A There was.

Q And was he put on antipsychotic medication?

A At that time he was, yes.

Q And prior to that time he was hospitalized in a private mental facility for a number of weeks?

A He was and unfortunately, and hindsight is 20/20, the -- and this had to do with the time as well. This was in the mid '70s, and we really as a field didn't understand that bipolar disorder was pretty common in children.

They missed a bipolar diagnosis, and they gave him antidepressant medication, which did nothing for the irritability, particularly his irritability that people picked up on later.

Nor did they do anything about the substance abuse.

There was nothing that I saw that indicated there was any, even despite some knowledge that there was substance abuse, any intervention. There was no referral. There was no opportunity for him, because he couldn't go on his own. Nobody referred him to a substance abuse program. He didn't get that when he was inpatient. He didn't get that subsequently. He did get some family therapy and some psychoanalysis, which is not appropriate treatment for substance abuse disorders.

Q And then he went to the Cambridge School of Weston, and what happened with his drug usage during his high school years?

A At that point it not only didn't abate, in some respects his repertoire broadened, because many of the kids there were using drugs; and he was exposed to even more elicit drug use, and he didn't receive treatment in that context for the drug use.

Q And that drug use in high school, did that include angel dust and LSD and marijuana, mushrooms and cocaine?

A Yes.

Q Then subsequently, after he went for a period of time to the University of Massachusetts, he went to transfer to a college out in California; is that correct?

A That's correct, San Francisco.

Q And what then occurred that justifies your reasons for

your opinion?

A What was clear to me is when he's clinically depressed, and starting with this first major episode, which I don't think ever really resolved fully -- there was some relief with the antidepressant medication, but in the context of continued drug use, a person can't get fully recovered from depression.

He goes to San Francisco and continues to use drugs and is so myopically focused, his reason is so impaired, that it gets to the point where he prostitutes himself to maintain a drug habit at the age of 19.

Not getting treatment again for drug abuse, what Mr. Arndt showed is classic. Fifty percent of all people with bipolar disorder don't understand their illness. This is a symptom of the illness. This is not coping strategy. This is not everyday denial. And it's common sense. Anybody who knows anybody with bipolar disorder or a substance abuse problem, a chronic one, knows what I'm talking about.

But we also now know, and "we" meaning the scientific community, understand this is a symptom of the illness. It's related to frontal lobe dysfunction. It is not a coping strategy. It is not response to the illness. It's a bona fide symptom of the illness, like a delusion, like depressed mood, like loss of appetite, like suicidal

ideation.

And his illness, I have to say in characterizing the syndrome, his major lack of insight -- and the technical term is anosognosia, A-N-O-S-O-G-N-O-S-I-A. And anosognosia is a syndrome that's related to frontal lobe dysfunction, which we know is highly common in people with bipolar disorder and certain kinds of substance abuse. Frontal lobes are shut down. He is not aware he's got a substance abuse problem. That's abundantly clear from the very beginning, from the onset of his illness 30 years ago, both illnesses, mood disorder and his substance abuse disorders.

Q And what happened subsequently?

A He got somewhat of a handle on his substance abuse in the sense that he was able to finish college. He was able to excel. He was able to do volunteer work. All of the recommendations I read for medical school and subsequent placement he had as a medical doctor clearly is that he was very bright and a compassionate, empathic person.

Not that he was without flaws. He certainly had some problems but, for the most part, he was able to succeed.

And his account of his drug usage at that time confirms that.

He was using drugs recreationally.

Very importantly, he was not clinically depressed.

The depression had finally run its course. He was not dealing with the kinds of depressive symptoms that he was dealing with when he was a teenager and throughout his 20s and early 30s.

And I think that is clearly why he was able to get a handle on the drug use.

Again, people around him, you know, at least from a distance never -- from a distance never would guess that this highly accomplished, intelligent person who seemed to be functioning in a world is doing okay.

If he was clinically depressed, I think it would have been a different story.

Q You relate in your report that after graduating Harvard Medical School he did his internship at Beth Israel Hospital and then he did his residency in the joint Harvard Orthopaedic Program; is that correct?

A Yes.

Q And then he went and did a special spine fellowship at Tulane University?

A That's correct.

Q And what happened there?

A This -- the Tulane period, and this was back in 1998, is another very significant period of time for him, and for one main reason -- two main reasons. Sorry.

He's getting depressed again. He is clearly

getting depressed. He gets the fellowship. His long-time partner, his lover, doesn't want to go with him to Tulane. He's depressed about that, and his depression -- and about some other things. But the point is this is not a normal depression. He gets into another very severe episode of depression, and like when he was 15, he can't see past, you know, what's right in front of him. And what's right in front of him is one thing, ending the pain, stopping the self-loathing, stopping the depression, stopping the excruciating pain that comes with a severe episode of major depression.

So he plans a suicide at Tulane. He's going to tape up the windows and turn on the gas, and like when he was 15, he just wants it to stop.

And, unfortunately or fortunately, depending on how you look at it, he is introduced to smoking crystal methamphetamine, and he has described to me and to the parole officer who did the report and to Dr. Michael Fayne and others, his experience of smoking crystal methamphetamine for the first time, and it's very similar to other reports I've heard with this difference, it's a depressed patient that's describing smoking it.

What he describes is for once not having that pain, for once not feeling the self-loathing, not feeling depressed.

He feels like he feels when he's doing surgery. He feels like God, and he is not talking about the arrogance of God. He's talking about being at peace.

Unfortunately, as I think most people realize, especially when taken in this form, it's a highly addictive drug, behaviorally, psychologically, and physiologically. And this really starts about a five-year term of escalating use of crystal meth and smoking it.

Q And the conduct that occurred that resulted in his conviction in the federal district court in New Orleans for filing a false affidavit, did that occur after he was using the -- smoking the crystal meth?

A Yes, it did, because he went to Los Angeles, and that's where a friend of his turned him on to it.

But it also occurred in the context of a very severe clinical depression, and from that period of time, going on for another five years, we're looking at somebody who, like when he was 15 to 19, is not getting relief from the depression, because he's abusing drugs.

And he's getting prescribed antidepressants. He actually was in therapy for four years, and in therapy he comes in and he talks about in great detail his past drug use, and the therapist never follows up on it.

I looked at four years of therapy. There is not follow-up on a very forthcoming patient describing a long

history of drug use and abuse. He lied to his therapist. He said, But I'm not doing it anymore. I'm just using Xanax occasionally.

Any therapist with training in substance abuse disorders doesn't take that statement as the final word, because we know that people when they are addicted lose the ability oftentimes to be -- to use their rational judgment. And here he is asking for help for his depression. As a doctor he should know he can't continue to use drugs, yet he lies to his therapist.

But unfortunately for Dr. Arndt, in fairness to somebody who is an addict at this point and clinically depressed and looking for help, his therapist never follows-up with him, by the therapist's account. He never really challenges him, asks him, Are you sure you're not using?

He notes the depression that goes on for four years, never asks him, Are you sure you're not out partying at night, and so there is no follow-up. There is no opportunity there in that relationship.

Q What is the mechanism, if any, between Dr. Arndt being a physician using drugs, serious, dangerous drugs, and not realizing and not being able to change his behavior?

A That was important in my opinion about the diminished capacity.

Dr. Arndt for many years has had the responsibility of deciding how much of a drug is okay. Any drug can be abused. And given the anosognosia, his lack of insight, he doesn't have a problem, when he told his therapist I'm not using anymore, I am sure he knew he was lying to his therapist. But I also believe that he didn't, and I know this from talking to him about it, he didn't understand he had a problem. He had anosognosia. He had no clue he had a problem, and he didn't want to get sidetracked. He was handling it. From his perspective, he could handle this. He was, in a sense, prescribing the medication for himself.

He knew it was illegal. I'm not say that my opinion was that he wasn't sane, but he didn't understand the price he was paying. He certainly didn't understand how it was impairing his judgment, and in his judgment this is okay.

And he is not alone in this. We see this in a lot of physicians who abuse, and he is interacting with physicians at that time, several of whom are abusing, colleagues who are abusing crystal meth simultaneously. So he was not alone.

Q What additional stressors, if any, enter his life in 2001?

A Well, the -- we call it the Licensing Board in New York,

the medical board that --
Q The Board of Registration in Medicine in Massachusetts?
A Thank you.
Starts their investigation -- well, no. That was actually a little bit later.
Q Well, as a result of Dr. Arndt's conviction for the offense in New Orleans, he had to reregister in 2000. For the first time he had to disclose the conviction, and as a result of that, did you know that the Board of Registration in Medicine began an investigation of the status of his license to practice medicine?
A Yes.
And that was very distressing, and this was one of several social stressors for him at that time. And again this appears in the therapy notes. It appears in our conversations.
He was obsessing about it. He couldn't stop thinking about it. The depression started at Tulane, was never -- had never abated, had never been properly treated.
Q During this period of time, what, if anything, was occurring with his use of crystal meth?
A It got to the --
Q -- the smoking of crystal meth?
A It got to the point that it was daily use. And similar again to what happened when he was 15, when he starts using

marijuana and barbiturates daily, there is no longer any semblance of control over it. And the vicious cycle is self-loathing and depression, and he smokes the pipe and he feels okay, which, biologically is making his depression worse and impairing his ability to recover.

Q And even though he was on for part of that period still federal probation?

A Yes.

Remarkable lack of judgment.

Q Yes.

A But, again, his anosognosia -- I mean, to use a common term, it's denial. It's neurologically based denial. It is so extreme he is convinced he can handle it. He doesn't have normal judgment at that point in time and certainly has no ability to stop himself. I mean, he's facing major consequences. He cannot stop himself.

Q And then did you learn in the spring/early summer of 2002 the financial problems he was having in paying for attorneys to defend him in the Board of Registration cases, that that led to his leaving the surgery at Mt. Auburn Hospital that led to his suspension to practice medicine in the summer of 2002?

A Yes.

At that time he was paying two attorneys -- one was for immigration to help his partner stay in the country, and

the other one was for this investigation on his license -- and showing remarkably poor judgment, went and cashed a check while the surgery was still going on, left the hospital and went to a bank to pay an attorney who would only accept cash because he had bounced two previous checks.

Q And as a result of the temporary suspension -- or his suspension from the practice of medicine, what affect did that have on Dr. Arndt regarding his drugs use?

A Escalated it.

And, again, I can't talk about the escalation without noting that it is secondary to the depression. He became depressed and despairing. And I mean clinically depressed.

And right with that is an immediate myopic desire to relieve the depression, and he starts to use -- smoke the crystal meth on a daily basis, multiple times a day it eventually escalates to.

Q You have stated that this diminished capacity was in effect during the time that the offense conduct took place, and what relationship, if any, did this significantly reduced mental capacity have in relationship to the voluntary use of drugs? Was his use of drugs during this period of time voluntary on involuntary?

A In my opinion it was involuntary.

Q Why?

A A couple of reasons.

First of all, if you look at the history, you can see periods where he gains control. So there is just the heuristic. Empirically, you look at a person. Can they show some control, a desire to stop, cut back, and they actually succeed.

But, second, we see a clear progression from severe clinical depression to drug use. There has been a lot of research on this. I have had a lot of clinical experience with this.

There are people who are primary substance abusers that are people with mood disorders who are medicating their substance abuse, and if you do a thorough-enough history, you can untangle -- the chicken or the egg, which came first? And there's a very clear pattern of escalating, severely maladaptive use being on the heels of an episode of major depression.

Q So it's your opinion that his drug usage of crystal meth during the time period of the offense conduct was involuntary?

A Yes.

Q You asked Dr. Fayne to render an opinion in this case also?

A I did. I thought it was important to get someone like Dr. Fayne, if not Dr. Fayne.

Q Can you tell the Court who Dr. Fayne is and what his qualifications are?
A Dr. Fayne is a clinical psychologist in New York City, and for about a decade he was the director of the Smithers Drug and Alcohol Treatment Center in New York, and also the go-to person when you had a physician who was impaired. So when I had worked with physicians who came in ostensibly for things like depression and I realized there were substance abuse problems, I would make them go to Dr. Fayne's groups. He's had a lot of experience in this area. He's done research in this area, and I thought that for two reasons, one, it's just always good to get a second opinion, but the other one was with respect to the prognosis. I wanted to know what he thought.
Q Did Dr. Fayne render an opinion that agreed with yours?
A Yes.
Q And what is --
A I don't think -- did he opine specifically about diminished capacity? He certainly talked about the involuntary use of drugs, yes.
Q What was the prognosis that Dr. Fayne had for Dr. Arndt?
A Good, with specific parameters in place.
Q Would you describe those parameters?
A The parameters that should be in place, certainly during incarceration, he really needs to be in a drug program,

substance abuse program.

Upon release, at a minimum once a week, he needs to see a drug abuse counselor. He also needs to see somebody for the mood disorder. That would be for medication or other psychotherapy.

So two appointments once a week, and some kind of 12-Step program I think would be highly appropriate. If not a 12-Step program, some other daily therapeutic community is appropriate.

The critical period for people with this kind of -- this severe substance abuse problem is that first year when they're out. That's when you have most of the recidivism. So the more structure that Dr. Arndt can have when he gets out, especially that first year, if not the first couple of years, the much higher likelihood he will succeed.

What Dr. Fayne has talked to me about over the years and reaffirmed in his report, is that the research is clear that physicians have a much higher long-term recovery rate than the rest of the world. You look at other people that are of comparable socioeconomic status, you compare education, you control for race, IQ, and all that. The fact that they're physicians actually bodes well for recovery.

Q What have been your own observations from the time you first met Dr. Arndt until you saw him yesterday?

A Well, many things.

First of all, clinically he was far more ill when I first met him, depressed, disheveled and showing signs of somatic symptoms, thought disorder. His thinking was impaired.

I have seen a remarkable change since he has gotten treatment for the depression, and I do have some ongoing concerns that there is assessment of the bipolar illness. But beyond that, I think that the last two times I've seen him especially, his thinking is clear, his mood is good, his affect is good, he's hopeful, he has a vision for his life.

So clinically, and certainly by his own subjective report, he is probably doing better than he ever has because he is not using drugs.

Q So is this -- the period since he has been incarcerated, is that the longest period of his life since he was 14 or 15 years old he's been drug free?

A Since the age of 13, this is the first time in his life he has gone more than a week without using drugs, and he has had two and a half years -- a little over two years.

I've seen a big change in terms of his addictive personality. With addicts you'll see a lot of externalization, blaming the lover, blaming the system, blaming the government, blaming so and so, and Dr. Arndt did some of that when I first met him. And if we were having this hearing two years ago or a year and a half ago, I would

be giving you a different prognosis than I am today.

And that's one of the reasons I wanted Dr. Fayne to come in, because I saw a big change with the Lexapril, which is an antidepressant treatment that he was given.

But I also don't think it's just that. I think that with increased time where he's not -- where his brain is not being pickled, frankly, by elicit drugs -- in fact, he even said this to me yesterday. He said he feels like he's thinking more clearly than he ever has before, and he feels it's a result of being washed out of having these drugs in his symptom all the time.

And there's studies of that. You see people's memory improve, all sorts of cognition improvements the longer they're dried out.

So all those things together, I think he's talking about his addiction completely differently, not just yesterday, not just last year or the time before that. He is understanding his responsibility. He's understanding how he was taken over by this.

We have a lot of metaphors we talk about when we treat people. One is denial possession. The other is shutting the frontal lobes off. That's physiologically what happens. He understands that, and he understands he cannot control it; and, more importantly, he now understands that even when he was doing his residency and not getting in

trouble, he wasn't controlling it then.

And that's a big difference than the conversation I first had with him. He wants to be able to be in control. "There's long periods where I could control it." But he understands now he actually wasn't controlling it. He was breaking the law. He was breaking the trust of his patients and his mentors. I mean, he sees it completely differently now than he did when I first met him.

Q I just have two more quick questions.

I showed you Dr. Biolio's letter to the Court yesterday, didn't I?

A Yes, sir.

Q And Dr. Biolio is a Ph.D. and nurse practitioner in the Norfolk County House of Correction, and he treated Dr. Arndt when he came in and referred him to a psychiatrist when he felt Dr. Arndt was suicidal and going to die. And I take it in the letter from Dr. Biolio he said in over 20 years this is the first time he has ever written a letter.

What is consistent with your diagnosis and your prognosis for Dr. Arndt that you also saw, if any, in Dr. Biolio's letter to the Court?

A There are two things that were highly consistent, and frankly, it's just always reassuring to see things that are consistent; and if they're not consistent, you have to rethink things, make sure you did everything appropriately.

But what he said in his letter matches what I have seen, which is that Dr. Arndt is far better clinically with respect to his mood disorder. The treatment has worked.

With respect to his attitudes about his addiction, with respect to his ability to actually recover from this and do well, he describes many of the same things I described and is hopeful for him as I am.

Q What effect -- what have you learned about Dr. Arndt's religious studies, and what effect, if any, do his religious studies have on his future?

A Dr. Arndt has a very active mind and was drawn into Talmudic studies with the reverend -- the rabbi who has been visiting him, and has taught himself Hebrew. But I've also learned, and what's most interesting to me clinically, what he wanted to talk to me about -- and I've forgotten the Hebrew word, I'm sorry, because I wanted to remember it, but it has to do with offenses and the importance of rules.

As many people know, the more orthodox forms of many religions, Judaism being one of them, there is a lot of rules about how to live your life.

And he was very -- I was just very struck by his desire to try to not bend rules, and had a very interesting exchange about the magazine that you gave him that was potentially breaking the rules, and he didn't want to do that.

I think he understands -- why I am smiling, why I think that is a hopeful sign is, frankly, he is humbled by his addiction. He understands he can't bend the rules. He understands every time he bends rules he hurts people, himself, as much if not more than anyone, but his focus has been on other people for the most part.

Q So is it fair to say that with his underlying mental illness and his proclivity for depression and soothing that depression with drugs, that he will have to be vigilant lifetime and have basic therapeutic structure over time?

A He will have to be vigilant of everyone and anyone in his life, whether it's the courts, his family or his friends, he has to be vigilant. This is a life-long disease. He doesn't walk out the door cured, and he needs to be vigilant, but also the community that's attached to him needs to be vigilant.

I'm not trying to dilute his responsibility. It's just -- it doesn't work unless there's help.

Q And then finally my last question.

To what extent, if any, did Dr. Arndt's reduced mental capacity contribute to the commission of these offenses?

A Again, I am sure within a reasonable degree of professional certainty he would not have done any of these crimes had he not had these disorders and had they not been,

both of these disorders, exacerbated, the mood disorder and the substance abuse disorder.

MR. DELINSKY: Thank you.

No further questions.

THE COURT: Ms. Rue.

MS. RUE: Thank you, your Honor.

CROSS-EXAMINATION

Q Dr. Amador, you said that you reviewed the therapist's notes.

Those were the notes from Richard Caplin; is that right?

A Yes.

Q Did you actually speak with Dr. [sic] Caplin?

A No.

It's "Mr." Caplin.

Q Mr. Caplin?

A No.

Q You found that he did not follow-up on the depression?

A I'm sorry?

Q You found that Mr. Caplan did not follow-up on Mr. Arndt's depression?

A No. What I said was if I -- and if I misspoke, I apologize.

That he did not follow-up on the substance abuse problem. In fact, he wrote extensively about how depressed

Mr. Arndt was.
Q And you found indicia of substance abuse in Mr. Caplan's notes?
A During the intake evaluation, during the first couple of meetings, yes.
Q And it was malpractice for him not to have followed-up on that?
A I don't think that I use that term. I think it was inappropriate. I think clinically that if you are faced with a clinical history that includes significant polysubstance abuse, you are absolutely obligated to assess that early and in an ongoing way for the entire time you're working with that patient. Because substance abuse disorders are diseases that last a lifetime. Exactly what I said earlier.
Q And in your view Mr. Caplan did not do that?
A Absolutely.
Q And he had an obligation to do that?
A Yes, I believe so.
Q And you've spoken with Mr. Caplan about that?
A No.
Q You referred Mr. Caplan to the appropriate boards for his failure to do so?
A I didn't say he committed malpractice, but I do think it was inappropriate.

Q You would agree with me, would you not, meth is generally, for anyone, a highly addictive drug?
A A percolin drug and highly addictive.
Q Damaging?
A Yes.
Q For anyone?
A Yes.
Q It is a drug that causes thought disorders in anyone who smokes it?
A Yes.
Q It is a drug that causes long-term health problems for anyone who is addicted to it?
A Long-term health problems generally --
Q Yes.
A -- wide range?
Sure.
Q It is a drug that causes lack of judgment for anyone who uses it on a permanent basis?
A Can cause lack of judgment, yes.
Q There are people who don't have lack of judgment when they're using meth?
A Well, it depends on your lack of judgment. This is not a unitary construct judgment. It's what instance or what scenario you have.
Q Some people use it and their judgment is just fine?

A Sometimes the judgment in some areas can be fine and other areas impaired.

I mean, people who use --

Q No.

A I'm sorry.

Q Mr. Arndt told you that he was able to avoid using drugs while he was doing surgery; is that right?

A That's correct.

Q And you have accepted that? You've assumed that that was true?

A I don't have any reason to assume it's not true. I have some reason to assume it is true. I have not seen any reports from coworkers or reprimands, and I've looked at hospital records, that he's never been written up for being caught with a pipe in his locker or that he stepped out for 20 minutes to go to the bathroom, and people find him out in back smoking, no reports of that.

Q So in your view he was able to control his drug usage while he was a surgeon?

A To some extent, yes.

Q And you agree that he then had volition over his drug usage during that time?

A If he chose not to smoke crystal meth prior to surgery, absolutely. He's showing voluntary -- he's showing control.

Q Now, you state in your report that he was 38 when he was

first alleged to have committed a criminal act?
A (No response.)
Q Page 18 of your report. Do you have your report in front of you?
A I do.
Could you direct me?
Q The top paragraph on page 18, At 38 years, worried that he would be expelled from the country, David submits a fraudulent affidavit in support of this application. This is the first time he is alleged to have committed a criminal act.
Those are your words; is that right?
A That's correct.
Q But you were aware that he used marijuana at age 13?
A Yes.
Q You were aware that he used LSD at age 14?
A Yes, and I was aware he was a prostitute in San Francisco at age 19.
Q And he was charged with that?
A No, I wasn't aware of that until yesterday, actually. I didn't see that, but Mr. Arndt told me about it.
Q You indicated that the source of your information that you relied on for your report included the PSR; is that right?
A Yes. I didn't see that in the first version. I may

have missed it if it was there.
Q So when the PSR sets forth his criminal charges, you didn't pay attention to them?
A If it's in the initial PRS that I reviewed last year, then I certainly missed it.
I wouldn't characterize my attention span as not paying attention to it, but I would have missed it if it was there last year.
MS. RUE: May I approach, your Honor?
THE COURT: You may.
Q I've handed you a document which I will represent is the presentence report prepared in this case, and at the bottom of it it has a date, does it not, indicating when it was prepared?
A Yes. September 13, 2005.
Q And there's a blank after the word "revised"; is that correct?
A Correct.
Q So this was, in fact, the PSR that you reviewed; is that right?
A It certainly appears to be, yes.
Q And turning to page 18, paragraph 66, it reports that he was charged with prostitution in 1979 at age 19?
A Yes.
Q You were aware that Mr. Arndt was married; is that

right?
A I'm sorry, that he was?
Q You were aware that he was married?
A Yes.
Q You were aware that he was gay?
A Yes.
Q And the woman was gay; she was homosexual?
A Yes.
Q He married her to get her into the country?
A Yes. That's what he told me.
Q And, in fact, the marriage had so little substance to it you didn't even put it in your chronology; is that right?
A I didn't find it relevant.
Q You didn't find it relevant? He was married for five years and that wasn't relevant?
A Married in the way you described, not as husband and wife, yes.
Q Arndt is capable of telling the difference between right and wrong; is that right?
A Yes.
Q He knew that LSD was illegal?
A Yes.
Q He knew that marijuana was illegal?
A Yes.
Q He knew that cocaine was illegal?

A Yes.
Q He knew that methamphetamine was illegal?
A Yes.
Q He knew that stealing cocaine from his housesitter was illegal?
A Yes.
Q He knew that writing prescriptions for people who were not patients was illegal?
A Yes.
Q You believe that Arndt was forthcoming about his prior offenses when he talked with you; is that right?
A Yes.
Q He admitted to you that he had sold methamphetamine?
A Yes.
Q He admitted to you that he had given Oxycodone prescriptions for one of his methamphetamine suppliers?
A That's correct.
Q He admitted that he used Ketamine while on probation?
A Yes.
Q And you found that relevant?
A Yes.
Q You found it relevant to your finding that he was forthcoming, he was being honest, that he was accepting his drug use?
A The last example, yes.

Q Yes.

You are familiar with the safety valve, are you not?

A Yes.

Q You know that to qualify for the safety valve a person has to be fully forthcoming with the government?

A Yes.

Q That if the government asks about a topic and the person holds back, the government can simply report to the court, this person wasn't forthcoming, the safety valve does not apply?

A That's my understanding, yes.

Q And you understand then if the safety valve doesn't apply, a minimum mandatory sentence is in place and a judge is stuck with that?

A That's my understanding, yes.

Q And the defendant is stuck with that?

A Yes.

Q So when Arndt provided information about his drug use on probation, the government already knew about it, and it was in his self-interest to report it, wasn't it?

A Yes.

Q And Arndt was obtaining methamphetamine from Charles Ghera?

A Yes.

Q He was providing Oxycontin scripts to Charles Ghera?
A That's correct.
Q And Ghera was charged with distribution of ketamine?
A Yes. I'm aware of all that.
Q Ghera was one of the witnesses against Arndt?
A Yes.
Q So it would be natural for Arndt to provide information about a person who was a witness against him, wouldn't it?
A Could you repeat?
Could you be -- I am not sure what you mean by "natural".
Q It would be in his interest?
A His interests, yes. Absolutely. Sure.
Q You have received information from Arndt about his leaving the patient on the OR table; is that right?
A Yes.
Q You have no independent knowledge about that; is that right?
A Other than news reports. I would have to double check my sources. I believe that's it.
Q You didn't interview the attorney that he said he was depositing money for?
A No.
Q You didn't have an independent basis to know whether he was going to deposit money for an attorney or deposit money

to pay for methamphetamine?
A That's correct.
MS. RUE: Nothing further.
THE COURT: Mr. Delinsky, anything further?
MR. DELINSKY: I'm done, your Honor. Thank you.
THE COURT: Thank you very much, Doctor.
THE WITNESS: Thank you.
(Witness excused.)
THE COURT: Apparently there's some request for a recess. So let me honor that, and let's take a brief ten-minute recess.
THE CLERK: All rise.
Court is in recess.
(Recess.)
THE CLERK: All rise.
Court is open. You may be seated.
THE COURT: Mr. Delinsky, do you have anything further by way of witnesses?
MR. DELINSKY: No, I do not, your Honor.
THE COURT: Okay.
Before I call on Dr. Arndt, if he wishes to speak, do counsel wish to add anything based on the hearing?
MS. RUE: Yes, your Honor.
Your Honor, the defendant has made a presentation

that he is entitled to a downward departure as well as a Booker adjustment based on his diminished capacity.

The government submits that based on his testimony that simply is not the case, and US v. Williams, which is 891 F.2d, 962, a First Circuit case from 1989, the First Circuit specifically rejected under the Guidelines voluntary drug use as a reason for a downward departure.

It's true whether it's addiction. It's true whether it's voluntary drug use, and there is no question here, even conceded by the psychologist who just testified, that this is drug use that started out as voluntary. And he was voluntarily using drugs when he was trading methamphetamine for Oxycondone prescriptions. He was voluntarily using methamphetamine and Ketamine and whatever other host of drugs while he was on probation. He was voluntarily snorting methamphetamine for 15 years. He was voluntarily smoking methamphetamine.

There is no question here that the guideline applies that was applied by the First Circuit in US v. Williams.

In that case the court, the First Circuit actually, reversed a sentencing court that had engaged in a downward departure for drug addiction. The First Circuit in that case noted that in enacting the Sentencing Guidelines and the legislation enacted, Congress sought to achieve three

primary sentencing goals: Honesty, uniformity, and proportionality.

So here where Booker guides the landscape and now the Court has the ability if not to downward departure for voluntary drug use, to depart under 3553, the government submits in order for the Court to do so it would have to find that there are clearly identified and persuasive reasons to downwardly depart that exceed the need for proportionality, that exceeded the need for honesty and uniformity in the sentencing system, and those simply don't exist here.

This is a defendant who has had every opportunity thrust to him. He got breaks through the criminal justice system. He married, brought in somebody illegally, learned from that that he could do this, and lied on someone's immigration application, which should have been a felony. It was charged as a felony. He contested it on grounds that he wasn't getting equal rights as a homosexual to bring his lover into the country. When he lost that, he then was able to plead to a misdemeanor, which arguably was going to allow him to keep his license, and he got three years' probation. And during that probation he used cocaine. He used meth. He started trading meth for Oxycontin. He started illegally submitting drug scripts to his methamphetamine supplier.

This is a defendant who's had opportunities to

conform his conduct to the law and he chose not to.

Under the case law of the First Circuit, under 3553, for respect for the law, the seriousness of the offense, deterrence and parody of like defendants, your Honor, we submit the Guidelines sentence is appropriate.

THE COURT: Mr. Delinsky, do you have anything further to add?

MR. DELINSKY: Yes. Yes, your Honor, just briefly.

The voluntary use of drugs is no excuse for the commission of crime. I know that. I think Dr. Amador gave a long, detailed and persuasive analysis of David Arndt that traced the foundations of his serious mental illness, approximately from the age of 13 or before, and described its origins, described a childhood illness that has a high correlation to mental illness, described certain genetic characteristics, described a clinician's review of it, described two early serious attempts at suicide with hospitalizations, and clearly rendered an opinion that Dr. Arndt has diminished capacity.

No one is saying that Dr. Arndt lacks the ability to know right from wrong. This is not an insanity case. No one is saying that Dr. Arndt was some robot, but what Dr. Amador said, and remains uncontradicted, that his drug usage vis-a-vis the crimes in question was involuntary, and

that there was an underlying mental illness.

So the case that's cited by the government, which I well know, is completely inapposite of this, because there was no evidence submitted in that case to this underlying mental illness and the causal connection between a detailed medical history with drug addiction. And Dr. Amador clearly laid out the requirements of diminished capacity.

With respect to the presentence report, your Honor, on page 22, paragraph 79, the defendant voluntarily disclosed in his interview to the probation officer that on April 17, 1982, he married Shirla Nobombi [ph.] in Bombay, India. He reports that he married Shirla as a means to help her leave India because of her fear of prosecution for being a homosexual. This marriage concluded with a divorce on September 11, 1987, and the defendant notes no children were born to this marital union.

From what I understand, Ms. Nobombi would have been subject to great abuse and potential harm if she remained in her country to live her lifestyle. She is a United States citizen, and she has a very high position in private business today in the United States.

The ability of this Court to craft a sentence that can find justice has been enhanced by Booker and by the case law of the First Circuit.

I have tried to structure my argument and the brief

that I filed not based upon a whimsical desire for this Court to show mercy, but to try to show under established principles of the Guidelines as guidance why Dr. Arndt qualifies for relief. And if he qualifies for relief under the Guidelines, under well-recognized departures and/or adjustments, that's not in violation of the statute. That's in conformance with the statute.

As your Honor knows, the Guidelines as originally written limit all, except for very limited areas, personal characteristics of the defendant as grounds for adjustments. That's all been changed by Booker because of the reference to the statute and the criteria under the statute.

I had written two questions for myself to try to answer for the Court.

One, why did David Arndt do what he did; and, two, why, if this Court takes a chance on him, he won't do it again?

I think it's clear and uncontradicted that David Arndt has a disease that in our society is very difficult to understand, and it's complex when it's applied in the law, mental illness, and how that mental illness relates to and has a causal effect on crime.

If he had a serious disability, a life-threatening illness that impaired his ability to go forward, all kinds of arguments could be made. But the evidence is

uncontradicted that he has had a serious mental illness since he was a young boy, and it has affected and distorted his entire life.

And but for the mental illness, Dr. Amador said he would not be here before this Court today.

Why should this Court take a chance on him?

Should this Court just throw away the keys and say, okay, follow the government's recommendation, 170 months, which is almost 15 years in prison, or say, does this man have some hope of salvation?

What has he demonstrated to the Court?

I don't think Dr. Biolio, who said he's never written a letter before in 20 years except for this letter, as somebody who can con a correctional officer. I don't think Dr. Amador was conned. I don't think Dr. Silen was conned, who talked about what this young man was when he left medical school, what his potential was. And I don't think the rabbi is making up stories as to his serious commitment in his studies.

There is a fine line between hope and punishment for the sake of punishment. The law as we know it now provides that the Guidelines have to give this Court guidance. It's a body of law, it's a body of precedence, that this Court should look to, but the Guidelines are advisory.

The First Circuit has recognize that even in the case of the safety valve the courts now have, quote/unquote, Booker discretion.

I think, taking the lessons from the Thurston case, I have tried to tailor traditional departures justified under the Guidelines, which I believe we have met, to give the Court an opportunity by applying the advisory Guidelines or applying the lessons of Booker and taking these additional factors and applying it to the statute, that this man is entitled to justice that the Guidelines itself do not provide, and this is a perfect case of why this case is out of the "heartland."

You have before you a sophisticated, talented, human being who has a disease, and Dr. Amador has testified in detail how that disease has affected his life; and from the time he was 13 years old he began to abuse drugs to relieve the serious pain that he was suffering from, and Dr. Amador spoke about the recurrence of depression throughout his life, and how that depression evidenced itself and what it was like. And that's the bipolar aspect of the disease, the depressive aspect, as opposed to the manic aspect.

We are not saying that Dr. Arndt deserves no punishment. He does deserve punishment. He does deserve incarceration, but I believe he deserves incarceration with

a hope that at his age of his mid 40s he will not be an old man when he leaves for essentially a nonviolent crime for which he has a causal effect because of this underlying mental illness, a man that is otherwise good and decent and whose untreated mental illness, which Dr. Amador said was biological, and its denial that there was a biological component to it, an organic component, and he described the medical term for it, that that should be taken into consideration by this Court.

I feel that if Dr. Arndt is put into the inpatient drug treatment program that the federal prison system has with strict conditions thereafter when he is released of supervised release, that will -- that this Court now has with its -- with the drug treatment provisions of the Drug Court, with weekly drug counselors, weekly meetings with a doctor to deal with the manic aspect of the disease, with serious structure, that there is hope that this man can contribute something positively to society. He's a decent person. He has a capacity.

And this case, from a personal level, has affected me greatly, because I have sought in some respects to try to find a way to persuade this Court that locking this man up for 10 or 15 years would idly thwart and undermine our whole system of sentencing, and consequently I have recommended a sentence of five years' incarceration.

And I would also add I would make a recommendation, if the Court would be so inclined to do it, that the Court recommend to the Bureau of Prisons that he do his time at Fort Dix. Fort Dix has -- it's one of the few institutions that has the inpatient drug treatment program. Plus, it's one of the very few institutions in the country that has an active religious Jewish community where he can continue his studies and also continue his learning of fences and boundaries which is, in itself, therapeutic.

So I would ask the Court to make a recommendation that his place of incarceration be Fort Dix. There are various levels there, your Honor. I won't ask the Court to make a recommendation, just that it be at Fort Dix, and let the department of prisons determine at what level, but recommend that in-house drug treatment program.

I think that the recommendation that I have made is based upon the law and it's principled and it's articulate.

Thank you.

THE COURT: Dr. Arndt, you are not required to address the Court, but you have the right to if you choose.

THE DEFENDANT: I'd like to.

I want to begin by expressing my sincere gratitude to the United States Attorney's Office, to the federal agencies, the officers who have been involved in my case. While protecting the public from me, you saved my life.

Were it not for your efforts and intervention, I'm absolutely certain I would not be alive today.

At the time of my arrest I was completely out of control. I do not believe that anything short of incarceration would have successfully interrupted my substance abuse, and I will never be able to ever adequately express my gratitude, for you, quite literally, saved my life. Thank you.

There are no words that can right the wrongs that I have committed, that can undo the harm that I have done or the hurt that I have caused. Nevertheless, I want to take this opportunity to apologize.

First and foremost, I want to apologize to my loving parents, to my family, to my friends, for the terrible hurt and sadness and disappointment and the unmanageable worry that I have caused them.

I want to apologize to my instructors, my professors, my mentors, my professional colleagues, and most of all, my patients, for my unconscionable and incomprehensible betrayal of their sacred trust and their faith in me.

I want to apologize to my community for bringing poison into its midst.

I apologize to society at large for having so thoughtlessly squandered the extraordinary gifts and

opportunities that life had lavished on me and this society had provided me.

And, of course, I apologize to the Court for my presence before you here today.

At the time of my arrest, I had managed to become everything I would not wish to be in this life. I cannot convey the sadness, the shame, the regret that I feel.

Please know with all of my heart and with all of my soul I am, and will forever be, terribly, terribly sorry.

It is my ardent hope in the days remaining that I may be able to create some opportunities to give some service to others. I would want to try to repair some of the harm and hurt I have caused to those who have loved me, those who have trusted me and put their faith in me, and to those who I have lived among. I am determined to try in some small fashion to make amends.

Thank you for allowing me to speak today.

THE COURT: Thank you, Dr. Arndt.

All right. It's a very difficult and very troubling case, and I do not mean to prolong the proceedings.

I am going to impose a provisional sentence, but there is one issue that has been raised that I do not think was sufficiently addressed either to the extent that I think I can make a final determination as a matter of law as to

the authority that I have under Booker with respect to the safety valve provision, or frame I think well enough, if I decided this issue adversely to the defendant, for the Court of Appeals to really understand the issue that I had in mind.

The facts of this case almost defy one's imagination. There is a popular television program that I have seen, "House" I think it is, which deals with the issue of drug-addicted physicians, among other social issues it raises; and I have a feeling if I tried to outline this story of how Dr. Arndt came before this Court as a plot, for even a program on the edge as that one is, I think it would be thought to be beyond one's imagination as plausible.

It is a tragic, tragic story to see a life with so much promise end up in the ruins that at least for some period of time it had.

I take some comfort in Dr. Amador's assessment that there's been real progress, and some comfort in Dr. Arndt's words of some recognition that he was on the verge of self-annihilation through the course of conduct he chose to follow.

There are three important findings I want to make now.

I was very impressed with Dr. Amador's testimony, and I accept his diagnosis that Dr. Arndt is drug dependent

and that that dependency can in a meaningful sense be explained or ascribed to a longstanding history of bipolar disorder.

I am also persuaded that while his illness does not rise to, as is appropriately conceded by the defendant, a lack of criminal responsibility in the legal sense of the term, the illness did contribute to a diminished capacity sufficient to cast meaningful doubt on whether he would have committed the crimes at issue but for the illness.

The guidelines as calculated by the government and by the probation officer I think are correct, and I think the applicable guideline result is 151 to 188 months, and that the government's recommendation appropriately is within the range that the guideline calculation produces.

When, however, I compare the advisory result that the Guidelines counsel against the common law factors as they are set out in the relevant statute, which we all know is 3553(a), I think the Guidelines exercise or produces a sentence that in my mind is more than sufficient and is greater than necessary, to somewhat turn the words of the statute around, to fit the circumstances of this case.

In looking at the common law and the statutory practice, I, of course, considered the seriousness of the offense and the community's need for deterrence of crimes of this type, and these are factors that weigh very heavily in

favor of the government's recommendation in this case.

I have also weighed, however, the need to protect the public from future crimes by this defendant, which I think is largely minimal, and, more appropriately, the ability to select a sentence that provides the appropriate rehabilitative and treatment services that will make this defendant restore his life.

The complicating factor, however, is the safety valve provision. Without the safety valve, Congress has enacted a ten-year mandatory minimum sentence.

One argument was developed in the briefs, and on that argument the government is surely correct. Almendarez-Torres is the law in this circuit. While I might as a trial court wish that I had the authority and the power to correct errors of the Court of Appeals, that is not an authority that I have and not one that I would be inclined to assert, absent some clear statement and direction from the Court of Appeals itself. And it seems to me that the government is right. They could not have been clearer, the view of the First Circuit not simply in panel but *en banc*; that is, until the Supreme Court tells me otherwise, Almendarez-torres remains the law of the United States.

Here I want to be very careful. There was a second argument raised which really was not addressed in the defendant's brief in anything but passing, although it was

begun to be developed in Mr. Delinsky's argument.

Understandably, the government really had no opportunity to respond to it. The argument is this. With respect to the safety valve, does Booker really allow the Court to have discretion to disregard a mandatory minimum sentence in the context of the safety valve if the Court finds that a criminal history point calculation in Guideline language produces a result that is not consistent with the seriousness of the offenses reflected?

The way the statute is written -- and here I am looking as 3553(f), which is the provision which incorporates the safely valve, it references the statute -- allows a court to make exceptions to the mandatory minimum sentence if certain conditions apply, and the one at issue here is the condition that a defendant not have more than one criminal history point as determined under the Guidelines.

Does Booker reach that language, or does it not, or does, in fact, the statute -- the underlying statute that addresses the mandatory minimum and imposes it in all cases but those to where this exception applies? Does Booker give the Court the authority to consider a sentence that technically would not comply with the safety valve as the Guidelines determine its contours?

What I am going to do today, because, again, I do

not think it fair to unnecessarily prolong the proceedings, although I do think it fair to give every consideration I can to the defendant and to the government before deciding this issue, and, if it is to be framed as an issue for appeal, I also want the record to be very clear as to the decision that I have made on this issue. So I am going to provisionally impose the mandatory minimum sentence today. I am going to stay execution of the sentence to give the parties an opportunity to brief the issue that I have described.

Let me ask you both. Have I described it clearly enough that you understand --

MS. RUE: Yes, your Honor.

MR. DELINSKY: Yes.

THE COURT: -- what I am reaching at?

Then I've accomplished at least that.

But, again, rather than unnecessarily prolong the proceeding, if I can decide on the basis of what you show me that the provisional sentence is the correct one, or at least the one I think is correct, that will be the sentence.

If I'm persuaded otherwise, we will renew the sentencing. But, again, I want to phrase this as carefully as I can. I want to make clear that I would have considered a different sentence, had I had more freedom than I, at least at the moment, think I have. And, who knows, perhaps

I do.

Mr. Arndt, if you would stand, please.

Mr. Arndt, pursuant to the provisions of the Sentencing Reform Act of 1984, and after having considered and applied the sentencing factors enumerated at 18 United States Code, Section 3553(a), it is the judgment of the Court that you be committed to the custody of the Bureau of Prisons for a term of 120 months, this term to be served concurrently on all counts of conviction.

The Court will make a judicial recommendation that you participate in the 500-Hour Comprehensive Drug Treatment Program.

Upon release from custody, you will be placed on supervised release for a term of five years. This term will consist of terms of five years on Counts One and Two, and terms of three years on Counts Three through Nine, all to be served concurrently.

Within 72 hours of release from custody of the Bureau of Prisons, you shall report in person to the Probation Office in the district to which you are released.

While on supervised release, you will not commit any federal, state, or local crime.

You will refrain from any unlawful use of a controlled substance or alcohol. You will submit to one drug test within 15 days of release from custody and at

least two periodic drug tests thereafter, not to exceed 104 tests per year, as directed by your probation officer.

You will, as the law requires, submit to the collection of a DNA sample as directed, again, by your probation officer.

You will comply with the standard conditions described at United States Sentencing Guideline Section 5D1.3(c), and shall comply with the following special conditions:

You are prohibited, as the law requires, from possessing a firearm or other dangerous weapon.

You will participate in a program for substance abuse as directed by the United States Probation Office. That program, again, may included testing, not to exceed 104 drug tests per year, to determine whether you have reverted to the use of alcohol or drugs.

You will be required to contribute to the cost of services for such treatment based upon your ability to pay or the availability of a third-party payor.

You will participate in a mental health treatment program if directed to do so by the United States Probation Office. Again, you may be required to contribute to the cost of this program based upon your financial capacity to do so or the availability of a third-party payor.

It is further ordered that you pay to the United

States a special assessment of $900. That shall be due immediately.

I do not understand that a fine is being recommended by the government, and it does not appear that the defendant has the capacity to pay a fine.

MS. RUE: That's correct, your Honor.

THE COURT: The Court will waive imposition of a fine as part of the sentence.

Sentencing having been imposed, I will now suspend execution of the sentence and permit the parties, 21 days --

MR. DELINSKY: Yes.

THE COURT: -- to brief the issue identified?

MS. RUE: Your Honor, I will be out of the country from January 5 through January 23.

THE COURT: If you can wait?

MR. DELINSKY: Yes.

THE COURT: I mean, it is important enough.

MR. DELINSKY: Yes.

THE COURT: All right.

February 1st --

MS. RUE: Yes, your Honor.

THE COURT: -- briefing will be completed on the issue that the Court identified.

Anything further?

MS. RUE: Your Honor, if I could actually have

through February 5th?

THE COURT: All right, February 5th.

MS. RUE: I have an evidentiary hearing on January 31.

THE COURT: All right.

MR. DELINSKY: Thank you, your Honor.

THE COURT: Thank you.

Mr. Arndt, we may be seeing one another again. We will see what the briefing results in.

MR. DELINSKY: Thank you.

MS. RUE: Thank you.

THE COURT: Thank you very much, counsel.

Is Dr. Amador still here?

MR. DELINSKY: Yes.

THE COURT: I had a question, Doctor. I found your testimony very interesting.

At one point you drew a distinction between what you called clinical and normal depression. I have never heard the term "normal depression" used before. What was --

DR. AMADOR: Everybody gets depressed.

THE COURT: Was that the distinction between normal mood swings?

DR. AMADOR: Clinical depression is depression that lasts two weeks, more days than not most of the day.

In addition, you have a constellation of other

symptoms, like you're not sleeping perhaps -- you don't have to have all of them, just four of them -- poor appetite, difficulty concentrating, loss of libido, feelings of worthlessness, suicidality, feeling like you wish you were dead.

Four of those with depressed mood for a couple of weeks, you've now transitioned from a normal depressed state, everybody gets depressed, to the disorder of depression.

THE COURT: But this distinction between "normal" and "clinical" is an accepted medical distinction?

DR. AMADOR: Oh, sure.

THE COURT: I just had not heard it before. Thank you. That was just personal inquiry.

THE CLERK: All rise.

Court is in recess.

(Proceedings adjourned.)

I N D E X

E X H I B I T S

(None.)

C E R T I F I C A T E

I, James P. Gibbons, Official Court Reporter for the United States District Court for the District of Massachusetts, do hereby certify that the foregoing pages are a true and accurate transcription of my shorthand notes taken in the aforementioned matter to the best of my skill and ability.

/s/James P. Gibbons
James P. Gibbons

February 28, 2018

JAMES P. GIBBONS, CSR, RPR, RMR
Official Court Reporter
1 Courthouse Way, Suite 7205
Boston, Massachusetts 02210
jmsgibbons@yahoo.com